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Building capacity—A framework for serving Albertans affected by addiction and mental health issues

July 2005

AADAC Alberta Alcohol and Drug Abuse Commission
An Agency of the Government of Alberta

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Executive Summary

In Alberta, in Canada, in North America and around the world, the needs of people with concurrent mental health and addiction issues have historically been addressed in a fragmented manner.

Substance abuse is a common concurrent condition among the mentally ill, and substance abuse is a common reason for relapse into mental illness. At the same time, untreated mental illness is a significant factor in relapse into substance abuse.

One of the strategic directions of the *Provincial Mental Health Plan for Alberta* is increasing service delivery system capacity to respond to the needs of people with concurrent disorders.[1] In the plan, the Alberta Alcohol and Drug Abuse Commission (AADAC) was asked to take the lead in working directly with health regions and other key stakeholders to develop a provincial strategy for addressing the needs of this population.

AADAC undertook consultations with a variety of stakeholders to inform the development of the strategy. Based on these consultations, this document proposes a framework for a collaborative systems approach in supporting Albertans whose lives are affected by concurrent disorders.[2]

Building on a solid foundation of existing models and approaches, the framework is intended to guide a wide variety of partners in providing services for people with concurrent disorders. It is a dynamic model designed to allow clients to enter the shared care system at any point, and move between points as their needs change.

Information, prevention and early intervention are emphasized as key strategies for people whose conditions are not severe enough to bring them to the attention of either the mental health or addiction treatment systems. This group is of particular concern because it is here that service providers may have the greatest impact on reducing harm and improving overall quality of life. In particular, the onset of most mental disorders occurs during adolescence and young adulthood. An emphasis on early intervention will contribute to reducing disruptions to a person's educational, occupational and social development.

For those whose needs are more pronounced, the framework is based on the principle that community services should come together, wrapping around the client in a way that complements the strengths of the client and his or her informal support system, rather than intervening in an intrusive way and potentially weakening the client's existing support system. A primary case manager, or single point of contact, would be essential for some clients.

[1] Provincial Mental Health Planning Project. (2004). *Advancing the mental health agenda: A provincial mental health plan for Alberta*. Edmonton, AB: Author.

[2] In this paper, the term "concurrent disorders" is used to describe co-occurrence of an addiction issue and a mental health problem.

Implementing this framework of shared care may require an infusion of resources, because in the short term there is not sufficient "stretch capacity" in the mental health and addictions systems. A resources gap analysis may be needed as a next step in implementing the framework.

Ultimately, the focus is to ensure that client needs are addressed in a co-ordinated and seamless manner. As Health Canada's Best Practices states, it is through synergy—a dedicated commitment from all partners—that the complex needs of this population will be addressed both in the short term and into the future.

Introduction

In Alberta, in Canada, in North America and around the world, the needs of people with concurrent mental health and addiction issues have historically been served in a fragmented manner. The service these people receive in addiction and mental health settings is often less than optimal—a situation that contributes significantly to poor client outcomes, and leads to overuse of resources in criminal justice, primary health care, child protection, and women's and homeless shelter systems.[1]

Substance abuse is a common concurrent condition among the mentally ill, and substance abuse is a common reason for relapse into mental illness. At the same time, untreated mental illness is a significant factor in relapse into substance abuse.

Despite the high correlation between mental health and addictions, people with severe and persistent mental illness report having difficulty accessing and remaining engaged in addictions treatment. At the same time, people who have an addiction are often excluded from receiving appropriate levels of mental health services. This is compounded by difficulty in finding and maintaining employment, adequate housing, child support, social assistance, vocational training, and other basic supports.

One of the strategic directions of the *Provincial Mental Health Plan for Alberta*[2] is increasing service delivery system capacity to respond to the needs of people with concurrent disorders. In the plan, the Alberta Alcohol and Drug Abuse Commission (AADAC) is responsible for taking the lead in working directly with health regions and other key stakeholders to develop a provincial strategy for addressing the needs of Albertans whose lives are affected by a substance abuse or gambling problem and a mental health problem.

This framework is the result of a series of focused consultations with health regions, physicians, clients and allied professionals, as well as input from the Alberta Mental Health Board and a number of national and international sources of best practice knowledge and research.

As a part of building the provincial strategy, health region staff, AADAC staff and physician representatives in most health regions worked together to develop next-steps action plans for implementation over a 6- to 12-month period.

[1] Addictions Foundation of Manitoba. (2003). *Co-occurring mental health and substance use disorders initiative (CODI)* [Electronic version]. Retrieved August, 2004, from http://www.afm.mb.ca/pdfs/Intro%20to%20CODI.pdf

[2] Provincial Mental Health Planning Project. (2004). *Advancing the mental health agenda: A provincial mental health plan for Alberta*. Edmonton, AB: Author.

Background

In Alberta, our health system has more than one organization whose expertise is critical to delivering treatment services for Albertans with addictions and mental health problems.

Alberta's health regions deliver community mental health services that are organized regionally and delivered locally.

AADAC is recognized nationally and internationally for its addictions information, prevention and treatment expertise. Addictions services are organized provincially and delivered locally.

Historically, mental health services and addictions services in Alberta operated independently of each other. Both services referred clients to each other and, at times, developed exclusionary criteria for some clients. In some areas of the province, there were excellent working relationships between service providers. In other areas, the AADAC office and the Alberta Mental Health Board (AMHB) clinic (then providing community and facility-based mental health services across the province) operated their programs in relative isolation from each other.

As a result, the cues that lead clinicians to explore certain aspects of the client's problems may be different in the two services. Consequently, the same symptoms may be perceived, diagnosed and addressed differently depending on which of the two systems the client seeks out. (The symptoms of certain mood and anxiety disorders are one example. In addiction services, these symptoms may be attributed to the neurotoxic effects of substance misuse, whereas in mental health services the possibility of the symptoms being related to substance misuse may not necessarily be considered as a causal factor.) To further complicate the development of comprehensive treatment plans, negative experience may have taught some clients not to speak about their psychological distress in addiction services, and to avoid discussing their substance use habits in mental health services.

In 1997, AADAC and AMHB identified the need to formalize a partnership to address the needs of Albertans affected by concurrent disorders. Since that time, a number of cross-ministry working groups have taken steps to enhance service delivery. These initiatives have met with varying degrees of success across the province.

The Provincial Mental Health Plan for Alberta identifies Alberta Health and Wellness as having overall responsibility for maintaining the provincial policy framework for mental health, entering into performance agreements with health authorities, monitoring results in achieving the expectations of the provincial policy, and meeting its legislative, policy and funding requirements.

In the plan, health regions are responsible for delivering the vast majority of mental health services. As an agency of the Government of Alberta,

AADAC operates and funds information, prevention and treatment services that address alcohol, other drug and gambling problems, including related research. The Alberta Mental Health Board plays an advisory role and is responsible for provincial leadership, collaboration, co-ordination and support activities in areas such as Aboriginal mental health, forensic services, mental health research, planning and co-ordination, performance standards and measures, provincewide prevention and promotion initiatives, and mechanisms for making decisions and providing treatment for extremely hard-to-serve clients.

Other provincial ministries are responsible for services and supports provided through cross-ministerial initiatives. Private providers, non-government organizations, community groups, self-help groups and consumer groups provide direct mental health and addiction services, including client and family support and advocacy.

Prevalence of Addiction and Mental Health Issues

In terms of incidence of mental illness, a Health Canada study[1] indicates that six million Canadians, or 20% of Canada's population, will suffer a mental illness in their lifetime. Three per cent will suffer a severe and persistent disability.

In terms of incidence of addictions, the literature indicates that

- 12% of adult Albertans are problem drinkers, 1% are dependent on illicit drugs, and 5% experience moderate to severe gambling problems.[2] [3]
- six million Canadians, or 20% of Canada's population, will experience a substance abuse disorder in their lifetime.[4] [5]

Several population-based and clinical studies have confirmed the high prevalence of co-existing mental health disorders and substance abuse:

- A study cited by the Canadian Mental Health Association (1997) suggested that in Edmonton, nearly one in three adults who are mentally ill also have a substance abuse problem.[6]

[1] Health Canada. (2002). *A report on mental illness in Canada*. Ottawa, ON: Author.

[2] Wild, T. C., Roberts, A. B., et al. (2004). Alcohol problems and interest in self-help. *Canadian Journal of Public Health, 95*(2), 127-132.

[3] Statistics Canada. (2003, September). *Canadian Community Health Survey, Mental health and well-being 2002*. Available from www.statcan.ca

[4] Smith, G. J., & Wynne, H. J. (2002). *Measuring gambling and problem gambling in Alberta using the Canadian Problem Gambling Index (CPGI): Final report*. Edmonton, AB: Alberta Gaming Research Institute.

[5] Health Canada. (2002). *A report on mental illness in Canada*. Ottawa, ON: Author.

[6] Alberta Alliance on Mental Illness and Mental Health. (2000). *Good people, good practices, not system: A discussion paper*. Edmonton, AB: Author.

Canadian Mental Health Association, Ontario Division. (1997). *Concurrent disorders: Policy consultation document*. Toronto, ON: Author.

- It is estimated that at least 50% of people who have a mental illness abuse illegal drugs or alcohol, compared with 15% of the general population. A British Columbia study found that over half (55%) of mental health service users had substance abuse issues accompanying their first episode of mental illness.[7]
- Sixty-five per cent of those seeking alcohol or other drug treatment in Ontario also had a psychiatric disorder.[8]
- American research has found that 37% of alcohol abusers and 53% of other drug abusers have at least one serious mental illness. Conversely, 29% of all people who are diagnosed with mental illness abuse either alcohol or other drugs.[9]
- In Canada, lifetime prevalence of substance abuse among the population with severe and persistent mental illness is about 50%.[10]
- Based on data collected through the Community Mental Health Evaluation Initiative, the prevalence of concurrent disorders among Canadian Mental Health Association clients exceeds 60%.[11]
- According to the results of the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), in which over 43,000 adult Americans participated, about 20% of people who reported misusing a substance (either at the time of the survey or within the previous year) had experienced a mood or anxiety disorder within the same period. Similarly, about 20% of people who reported having a current mood or anxiety disorder had abused a substance within the same period.

In a similar fashion with other addictions, people who have a mental illness are disproportionately represented among smokers. For example, 70%-90% of clients with schizophrenia smoke, compared with 23% of the general population.[12] Tobacco use remains the most important causative factor in a range of health issues including diseases, disabilities, hospital admissions, potential years of life lost, and premature deaths.

[7] B.C. Partners for Mental Health and Addictions Information. (2003). *Concurrent disorders: Addictions and mental disorders*. Vancouver, BC: Author.

[8] Winnipeg Regional Health Authority and The Addictions Foundation of Manitoba. (2001). *Models of service for persons with co-occurring mental health and substance abuse disorders*. Winnipeg, MB: Author.

[9] National Alliance for the Mentally Ill. (2004). *Dual diagnosis and integrated treatment of mental illness and substance abuse disorder* [Electronic version]. Retrieved August 20, 2004, from http://www.nami.org/Content/ContentGroups/Helpline1/Dual_Diagnosis_and_Integrated_Treatment_of_Mental_Illness_and_Substance_Abuse_Disorder.htm

[10] Health Canada. (2002). *Best practices: Concurrent mental health and substance use disorders*. Ottawa, ON: Author.

[11] Canadian Mental Health Association, Ottawa-Carleton Branch. (2003). *Evaluation of concurrent disorders "train the trainers" program*. Ottawa, ON: University of Ottawa.

[12] Lasser, K., Boyd, J. W., Woolhandler, S., Himmelstein, D. U., McCormick, D., & Bor, D. H. (2000). Smoking and mental illness: A population-based prevalence study. *Journal of the American Medical Association, 284*, 2606-2610; Ziedonis, D. M., Kosten, T. R., Glazer, W. M., & Frances, R. J. (1997). Nicotine dependence and schizophrenia. *Hospital and Community Psychiatry, 45*, 204-206.

Developing the Framework

In developing a comprehensive, evidence-based framework for a provincial strategy in Alberta, AADAC sought to incorporate experience, expertise and perspective from a wide variety of sources and partners. Along with an analysis of the current situation and major service system considerations (detailed in Appendix A), this process included the following key components.

Review of Existing Approaches

In seeking ways to build upon the strengths of Alberta's health system, a number of international approaches were examined. As well, the published opinions of leading experts in the field were reviewed. A detailed discussion of these models and approaches is provided in Appendix B.

Building on this foundational work, AADAC drafted a discussion paper as a starting point for developing a provincial framework. The paper reflected AADAC's belief in the value of building on the collective wisdom of service providers and disciplines involved in serving this population, strengthening collaborative relationships among providers, and working together to address service gaps.

Consultations

At the request of the Chair of AADAC, each regional health authority provided a senior contact person to work with AADAC staff to begin collaborative discussions. These contacts participated in designing a consultative process that was in keeping with the unique needs and interests in each health region.

A consultation day was organized in each health region with participants identified by the health region and by AADAC. Participants included senior clinicians, managers, physicians and allied professionals.

The consultations, facilitated by Alberta Community Development, provided a forum to

- inform health region staff, AADAC staff and physicians of the current situation (e.g., challenges, gaps and services being provided)
- exchange ideas about what is working well
- identify ways to improve access and service delivery
- enhance relationships with key stakeholders
- inform and guide organizational strategic and business planning
- clarify roles and responsibilities

Participants received a personal invitation to exchange ideas on how to develop a provincial strategy for addressing the needs of Albertans whose lives are affected by concurrent disorders. Participants were also provided

with a pre-reading package, and were encouraged to visit www.aadac.com to review AADAC's current and previous Business Plans.

As negotiated with the health region contacts, the consultations had two objectives: to provide AADAC with input on building a provincial strategy, and to open a dialogue between the health regions and AADAC about ways to enhance collaborative efforts. Consultations took place in eight regions, involving 71 health region staff, 12 physicians and 39 AADAC staff. One health region responded by submitting a position paper to represent its views.

Throughout the consultation process, AADAC received strong support from the regional contacts, and excellent ideas about what to include in a provincial strategy as well as areas of mutual interest where the two services could take immediate action to address issues and improve service capacity.

Feedback

In addition to these consultations, feedback was solicited from the Alberta Mental Health Board and the Addiction Medicine Section of the Alberta Medical Association. Expert opinions were also gathered from Dr. Ken Minkoff, Dr. Jerome Carroll and Dr. Louise Nadeau. Their expertise in this field is summarized in Appendix C.

Client Interviews

AADAC also conducted a series of client/advocate focus groups across the province to gather information about the experiences and perspectives of clients whose lives were affected by concurrent disorders, for the purpose of learning how to better serve their needs. One group discussion was held with youth.

A qualitative approach was used to conduct this study. Fifty-three people affected by concurrent disorders participated in semi-structured interviews ranging in length from 15 to 45 minutes. Participants were drawn from across the nine health regions, and male and female interviewees were approximately equal in number. At the time of the interviews, all clients were currently using services provided at detox, treatment or outpatient facilities.

The Framework for a Provincial Strategy in Alberta

Building on the available literature and input received from health regions, physicians, allied professionals, clients, the AMHB and opinion leaders in the field, AADAC is proposing a made-for-Alberta framework that is in keeping with Alberta's experience and the design of its human service system.

Principles of Service

As a foundation for a provincial framework, the following guiding principles are proposed for serving clients with concurrent disorders:

a. Accepting

Every person, regardless of the degree of disability, is considered to have the potential to achieve dual recovery, and is entitled to experience the promise and hope of full recovery. Recovery has been defined as a process by which a person with persistent, possibly disabling disorders recovers his or her self-esteem, self-worth, pride, dignity and life meaning through increased ability to stabilize the disorders and maximize functioning within the constraints of those disorders.[9]

Each clinical contact is welcoming, non-judgmental, hopeful, culturally sensitive, respectful and client-centred. Specific efforts are made to engage those who may be unwilling to accept or participate in recommended services, or who do not fit into available program models.

b. Accessible

Access to services is a fundamental precursor to patient/client engagement. As stated in British Columbia's Planning Framework,[10] "every door is be the right door" through which to receive treatment for concurrent disorders. People with concurrent disorders should be able to enter either an addiction service or a mental health service, and be provided with or connected to the unique combination of services they need.

The "door" through which people enter relies on a mutually agreed-upon process to engage them, to assess their strengths and capacities as well as their most pressing life circumstances, to build an initial treatment plan with them, to ensure referrals where appropriate, and to provide ongoing support and follow-up. In short, the "door" ensures access to the support required for people to achieve their treatment goals.

Twenty-four hour crisis services are available to provide welcoming and competent assessment and intervention for psychiatric and addiction symptoms. Where they exist, arbitrary barriers to mental health services based on alcohol or other drug use or length of sobriety are eliminated. At the same time, nobody is denied access to addictions services because of a co-existing mental health disorder and/or the requirement for prescribed psychotropic medication. For people with severe co-morbid conditions, continuous

[9] American Association of Community Psychiatrists. (2000). *Principles for the care and treatment of persons with co-occurring psychiatric and substance disorders.* Retrieved November, 2004, from http://www.comm.psych.pitt.edu/finds/dualdx.htm

[10] British Columbia Ministry of Health Services. (2004). *Every door is the right door. A British Columbia planning framework to address problematic substance abuse and addiction.* Retrieved November, 2004 from http://www.healthservices.gov.bc.ca/mhd

treatment relationships are initiated and maintained even when the person is either deliberately or inadvertently non-compliant with treatment recommendations.

c. Accountable

Using an accountability lens can help to give perspective on overall system performance, including the extent to which it fulfills the public trust by responding to identified needs and concerns. An accountability lens can also help to identify connections among improvement initiatives and interventions. These results can support synergistic outcomes, enhance system performance, and contribute to overall sustainability.

To that end, the system of services is designed according to accepted clinical and industry standards for serving this client population and their significant others. Performance targets and specific, quantifiable objectives are identified and agreed upon. Individual service and collective system response is measured to understand progress in achieving both annual and long-term performance measures. Consumer participation is encouraged.

d. Capacity Focused

The system of services builds, first and foremost, on the strengths and capacities of clients, families, informal support networks, communities and agency staff. With this foundation, the system seeks to complement what is already in place, rather than compete with it. The principles of community development and individual empowerment are embodied in system approaches.

e. Comprehensive

Albertans whose lives are affected by concurrent disorders have access to a full scope of services based on their needs.

Universal screening of clients is ensured. All people seeking help from addictions treatment services are screened for concurrent mental health disorders, and all people seeking help from mental health treatment services are screened for concurrent addictions.

A comprehensive assessment and treatment plan is dynamic, beginning with the person's first contact, and reviewed continually throughout the course of treatment. It aims to assess and integrate all relevant life areas, and establishes the direction and priorities for further treatment.

Both the addiction and the mental health issue receive appropriate condition-specific and stage-specific treatment, regardless of the status of the concurrent condition. One condition is not undertreated because another condition is present.

Services are designed to be capable of responding to the needs of mandatory as well as voluntary clients.

f. Evidence-Based

Regular, well-conducted research and evaluation provide the evidence required to formulate effective policies and practices, allocate resources efficiently and effectively, and support decision-making at all levels. Program-based research is supplemented with joint-ventured demonstration projects. Effectively transferring knowledge from research to practice involves making evidence-based information available and accessible through interactive engagement with key stakeholders, supported by user-friendly materials and a communications strategy.

g. Least Intrusive

The preferred level of service is least intrusive to the person, optimizes that person's adherence to treatment, meets the person's treatment objectives, and provides for his or her safety and security as well as that of others. Placement is based on using the least restrictive treatment option that is guaranteed to be safe and likely to be effective.

h. Sustainable

For a systemic approach to be successful, the full range of service options must be appropriately resourced. Wherever possible, services are designed within existing resources to have fundamental capability to meet the needs of the clients who are probably already being seen. Enhancements to existing service options will maximize capacity within existing resources, and have access to demonstration project funding. Where required, gradual expansion will take place as new resources become available. Salary inequities for similar roles across agencies will be addressed.

Funding policy initiatives are encouraged to support collaboration and provide for demonstration projects.

Characteristics of Service Delivery

In addition to the system principles outlined in the previous section, the services provided for clients and their family members reflect the following attributes:

a. Consumer Participation

Mutual aid groups such as Alcoholics Anonymous or Narcotics Anonymous, and advocacy groups such as the Schizophrenia Society enhance client and family participation. Where feasible to do so, Double Trouble groups and peer counselling options are developed and expanded.

b. Continuity

Clients experience a seamless approach to screening, assessment and treatment no matter where they first seek help. People with concurrent

disorders are viewed as having a combination of presenting symptoms that requires specific assessment and appropriately intensive treatment. Service sites have processes in place for ensuring a collaborative system of continuous care.

c. Individuality

The service is responsive and tailored to individual client needs, rather than fitting clients to the program. Continuous treatment relationships provide clients with a balance of appropriate case management and care, and appropriate empathic detachment (and, at times, empathic confrontation). This balanced approach provides opportunities for meaningful client choice and empowerment throughout the course of treatment.

Individualized treatment plans are based on an accurate screening and ongoing assessment of the person's condition and the degree of service co-ordination that he or she requires. There is no single correct intervention. Interventions are personalized according to presenting need, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, acuity, severity and motivation for treatment at any time. Treatment strategies are easily understood and supported by the client.

Empathic, hopeful, collaborative treatment relationships are recognized as one of the most important contributors to treatment success in any setting.

Where appropriate, each person has a primary clinician, or case manager, who co-ordinates ongoing treatment interventions.

People requesting assistance with housing, employment, child care, money for transportation, etc. are supported in getting this assistance even if they are not compliant with treatment recommendations.

d. Leadership

Service and system leadership is a key ingredient for ensuring progress.

Leadership includes

- articulating a shared vision for service delivery—one that ensures provincial consistency and maximizes local flexibility
- identifying champions in partner organizations
- building personal relationships when forging new partnerships
- establishing a positive culture and a "can do" approach to problem solving
- developing a scope of services to address the needs of all ages and predominant cultures
- ensuring the provincial and community-specific resources required to deliver a range of service options

- developing monitoring mechanisms that are outcome-focused
- keeping staff and organizational decision-makers informed and motivated while change occurs

e. Safety

Ensuring the safety of the client and others who may be at risk takes precedence over all other decisions.

f. Self-Determination

Clients are engaged in a non-stigmatizing, trustworthy environment and accepted where they are at in terms of how much program intervention or support they feel comfortable with at the time. Clinical and related information is shared in a way that respects the client's need for privacy and the provider's need for information.

Although abstinence is the most appropriate goal for the vast majority of addiction clients, it is important to acknowledge that there is a continuum of problems and needs. Even in treatment, some clients are neither ready nor able to engage in strictly abstinence-focused approaches. With that in mind, harm-reduction strategies focus on reducing or containing the negative consequences of substance use and gambling. The harm addressed can be related to health, social, economic or other factors that adversely affect the person, community, and society as a whole.

Harm reduction is complementary to the abstinence model of addiction treatment. While harm reduction emphasizes a change to safer practices or patterns of use, it does not rule out a longer-term goal of abstinence should the person decide to pursue it.

g. Service Co-ordination

Service co-ordination and collaboration is essential, especially for people with the most serious addiction and mental health issues. The client's goals determine the methods, intensity, frequency and types of services provided.

Clients are involved in case conferencing and case management; their family members are also involved when doing so is in the best interest of the client. Whenever possible, there is consistent collaboration and co-ordination among all health providers, family caregivers and external systems.

h. Stabilization

Once safety is ensured, issues that interfere with further treatment are addressed. Such issues include acute intoxication and withdrawal, psychotic symptoms, psychosocial crises, and severe anxiety or depressive symptoms.

A Collaborative Framework

The service system approaches reviewed in Appendix B share a common philosophical underpinning: a foundation built on collaborative partnerships. Health Canada's Best Practices report speaks to the development of enduring linkages between service providers or treatment units within a system, or across multiple systems, to facilitate the provision of services to people at the local level. Britain's Joint Liaison/Collaborative framework focuses on jointly managed treatment responsibility with one primary case manager. America's Substance Abuse and Mental Health Services Administration (SAMHSA) identifies the need for this client group to receive their treatment in mainstream systems of care that are well prepared to support their recovery. SAMHSA speaks against the creation of a separate system of care for people who have co-occurring substance abuse issues and mental health disorders. In support of these positions, the American Society of Addiction Medicine (ASAM) delineates a number of levels of program and staff capacities for serving people with concurrent disorders.

Best practice literature provides strong evidence for creating a collaborative framework involving all partners at all levels (community, regional, provincial and national), in order to develop a seamless system of care that enables clients to move freely between the entire range of human services they need.

In the same way that people with concurrent disorders are unique, the service systems through which they receive their care are equally unique—a reflection of the health services delivery system within individual jurisdictions. The New York Model,[20] as one conceptual framework, provides reference points for understanding each person's needs relative to the system's capacity to deliver a full range of service options. Building on the strengths of this model, a provincial framework of shared care is proposed for Alberta communities. The framework is adaptable to the particular strengths and capacities of individual communities. This flexibility makes it equally applicable to a major urban centre or a relatively isolated rural community.

Within a broad provincial strategy, the proposed shared care approach is one in which addiction and mental health service providers across the province would adopt a "shared care responsibility" for flexible service provision to clients with concurrent disorders, many of whom are most likely already being seen by mental health services, addictions services or both.

Building on this approach, each program and each clinician would be expected to develop fundamental "concurrent disorder capability" to provide properly matched services to the majority of those clients in current caseloads who are affected by concurrent disorders. Through consultation, collaboration and training, each component of the service system would be organized

[20] National Association of State Mental Health Program Directors, National Association of State Alcohol and Drug Abuse Directors, & New York State Office of Mental Health. (1998). *National dialogue on co-occurring mental health and substance abuse disorders*. Washington, DC: Authors. Retrieved August, 2004, from http://www.omh.state.ny.us

to help other parts of the system to develop its own capacity to the extent possible within existing resources. Each component also would work toward creating more specialized strategies and program approaches for clients whose level of complexity exceeds the core capacity of existing system components.

The following schema reflects the proposed strategic framework for Alberta:

to help other parts of the system to develop its own capacity to the extent possible within existing resources. Each component also would work toward creating more specialized strategies and program approaches for clients whose level of complexity exceeds the core capacity of existing system components.

The following schema reflects the proposed strategic framework for Alberta:

In this framework, counsellors and therapists contribute their collective knowledge, expertise and energies to screen, assess, and develop and deliver client-centred treatment plans, as well as information and prevention approaches that build community capacity. The client's addiction and mental health problems are addressed through a co-ordinated approach, with full regard for his or her unique needs and capacities. Whether delivered by a single provider or in collaboration with other providers, the service is seamless and transparent to clients and their significant others.

Building on the foundation of the New York Model, the schema identifies domains along a service continuum. These points are not static; the framework is a dynamic one in which clients can seek service at any point on the continuum, and move between and among domains as their needs change. For example, the point of access will be determined in large part by the client's most pressing issue, or the agency with which the client is most comfortable. Similarly, movement among domains may be influenced by changes in medication use or in the client's informal support network.

Although the model is primarily focused on the mental health/addictions scope of services, it recognizes that this client population also enters the human service system through a variety of other services including justice, children's services, etc. In many situations, these non-health-related service providers continue to carry the primary responsibility for the client and his or her needs, with support from mental health and addictions services.

The framework is not built on the idea that every client requires the direct involvement of at least two clinicians, one from mental health and one from addictions. This would be neither clinically, programmatically nor financially feasible.

Rather, concurrent disorder capability would be built into the activity of each clinician and each service, with a role for each that is appropriate to its mandate, its competency base and its existing concurrent disorder clientele. (See Appendix B for a discussion of ASAM's model of concurrent disorder capable and concurrent disorder enhanced services.)

Building a service's basic concurrent disorder capability may occur in a variety of ways, including

- direct training of existing staff
- hiring of cross-trained staff to provide on-site services to clients, and consultation and training to existing staff
- collaboration with another service provider to ensure a concurrent disorder capable service
- mentoring through such techniques as clinical supervision and job shadowing

Through co-ordination and collaboration, this framework has significant potential to reduce the redundancy in interactions and transactions that appear to be particularly problematic for this population.

The schema reflects a person-centred approach in which the client brings his or her personal strengths and is surrounded by a variety of formal and informal supports. Family and other collaterals are the first line of support for many people. Community services and agencies come together, wrapping around the person in a way that complements his or her strengths and those of his or her informal support system.

In each domain of the schema, a full range of service options is available to the client, including outpatient treatment, detoxification, in-hospital stabilization, short-term and long-term residential treatment, and access to specialized services as needed. In each domain, services are also available to address the needs of all age groups including children, youth and older adults.

The schema reflects the synergy that exists in a collaborative approach to treatment, sometimes through one agency assuming a primary role with support from another service, and sometimes through a sharing of primary responsibilities. No matter which service assumes a primary role, there is always a shared ownership and shared responsibility to help the client succeed. This is a model of shared caring.

In applying the model's theoretical framework to determine the suggested domain in which a person's needs are best met, addictions counsellors and mental health clinicians would begin with universal screening and in-depth assessment to define the nature and scope of the problem. Specific treatment recommendations would flow from the clinician's assessment and the client's goals for treatment.

The challenges implicit in the sharing of clinical information, the commitment required of service partners, and the need for an infusion of resources to achieve this model of shared caring should not be underestimated. To be successful, all partners will need to prioritize and commit their energy, their time and their resources.

With that context in mind, let's look at each of the domains of care:

Domain I

Domain I is consistent with the needs of people whose problems are not severe enough to bring them to the attention of the formal human service system, including the addictions and mental health treatment systems. This group is of particular concern because it includes many children and adolescents at risk of harm. Substance abuse and problem gambling by young people can result in substantial problems in educational, social, physical and emotional functioning. In addition, the onset of most mental health issues occurs during adolescence and young adulthood.

It is with this population that service providers may have the greatest impact on minimizing future harm by providing appropriate information, prevention and early intervention strategies. In particular, an emphasis is needed on information, prevention and early intervention to reduce disruptions to the educational, occupational and social development of those whose lives are negatively affected. An effective response includes the capacity for timely and relevant consultation and referral.

Information, prevention and early intervention should be provided in readily accessible settings including public health units, physicians' offices and other primary health-care locations, schools (where children and adolescents spend a major portion of each day), and locations where a high level of risk exists (including justice and child welfare services). The value of providing addictions and mental health information, prevention and early intervention services within these settings is intuitively apparent.

Mental health and addiction issues do not occur in isolation. Experience indicates that both are correlated with the determinants of population health (income and social status, physical and social environment, biology/genetics, education, employment and working conditions, social support networks, personal health practices and coping skills, gender, culture, healthy child development and health services). Rather than focusing on symptoms, strategies for information, prevention and early intervention must focus on the underlying influencers of addictions and mental illness. A co-ordinated approach, therefore, includes training a variety of service providers to screen for and recognize early signs and underlying influencers, and informing the general public about the warning signals and precipitators of mental illness and addiction.

A worthwhile prevention message for this population is, "To seek help is a strength, not a weakness." The cues that precede relapse should also be presented, so the person will know when it is time to seek help.

People whose needs are consistent with Domain I are the shared responsibility of a variety of services, including addictions agencies and mental health agencies. Prevention is everyone's business. Programs that contribute to public awareness, support risk reduction, reinforce protective factors, and foster healthier families and communities need to be mainstays of any provincial strategy.

Prevention strategies are cost-effective,[21] but they require a long-term commitment, and the ongoing reinforcement of messages and approaches that influence attitudes and bring about positive behaviour change.

[21] Addictions Task Group, & Kaiser Youth Foundation. (2001). *Weaving threads together: A new approach to address addictions in B.C.* Victoria, BC: Ministry For Children and Families.

Domain II

People whose needs are consistent with Domain II include those who have a more severe mental health disorder in conjunction with a less severe addiction problem. This includes people who may have experienced mild to moderate substance abuse and are not currently using substances or gambling. Examples of people who may be served within this domain include

- a person who has a diagnosis of anorexia, who used to binge drink (referred to as heavy episodic drinking) because it helped her relax enough to eat.
- a person who has bipolar disorder, who occasionally uses cocaine when he is depressed.

These people receive most of their treatment and follow-up support through community-based mental health services. Consultation with and, if necessary, referral to specialized addictions services including case conferencing and case management is used to achieve successful client outcomes. Mental health services carry the primary responsibility for facilitating a successful treatment outcome. Addiction services carry the responsibility at a secondary or collaborative level.

Domain III

Domain III is consistent with the needs of people who have a more severe substance abuse or gambling issue in conjunction with less severe mental health symptoms. These people may be unstable and actively abusing substances while demonstrating mental health symptoms (e.g., substance-induced psychosis). If the person is expressing more serious substance-related problems, he or she may require Domain IV services.

People whose needs are consistent with Domain III include those who present in addiction treatment settings and are often best managed by receiving care in that setting, with collaborative or consultative support from mental health clinicians. Once these people begin their treatment and are stabilized, they may benefit from community-based self-help supports like 12-step groups or the Schizophrenia Society.

Examples of people who may be served within this domain include

- a person with a trauma history, experiencing depression and self-medicating by simultaneously using alcohol and other drugs. This person would be a candidate for referral depending on the predominant client need.
- a married, employed man with alcohol dependence and bipolar disorder (stabilized on lithium). The client has experienced a series of relapses and has been mandated to residential treatment by the court system after an impaired driving charge. The client does not consider his drinking to be a significant problem. He says he experiences mood swings when he drinks alcohol.

In Alberta, these people receive the majority of their treatment and recovery support through AADAC's system of detoxification sites, area offices, residential treatment services and funded agencies. Addictions staff have a primary focus on the treatment of substance-related issues, but they also have the capacity to serve clients with relatively stable co-occurring mental health problems.

Close liaison with the self-help community is an essential component in the person's recovery. Consultation with and, if necessary, referral to specialized mental health services including case conferencing and case management is used to achieve a successful client outcome. Addiction services carry the primary responsibility for facilitating a successful recovery. Mental health services carry the responsibility at a secondary or collaborative level.

Domain IV

Domain IV includes people who have a more severe mental health disorder in conjunction with a more severe substance abuse problem. This group includes those with severe and persistent mental health problems. These people may present at an addiction treatment setting while they are simultaneously experiencing mental health problems, or at a mental health setting when they are seriously drug- or gambling-dependent. They may not have been previously diagnosed with a mental illness.

These people typically require more intensive stabilization interventions for an assessment to be completed and a treatment plan to be developed. Generally speaking, once the more serious mental symptoms are stabilized and initial substance-related problems are addressed, the person may be served appropriately in another domain.

Examples of people who may be served within this domain include

- a homeless person with a history of physical and sexual abuse, who presents regularly at the local shelter under the influence of alcohol and crack cocaine. She demonstrates signs of an active psychosis, denies having a drug or alcohol problem, reports frequent visits to the hospital emergency department for both mental health and physical problems, but refuses treatment. She appears suspicious of staff in all settings and refuses all offers of medication, but does not seem to be a danger to herself or others.
- a person with a history of personality disorder and chronic depression as well as a long-term struggle with crack cocaine dependence, who presents at the local medically supported detox expressing suicidal ideation. This client's history reveals that his ex-spouse has a restraining order against him. The client is knowledgeable about the use of explosives and has threatened his ex-spouse.

For the most part, these people require access to specialized "concurrent disorder enhanced" services delivered collaboratively by a multidisciplinary team of mental health specialists and addictions specialists.

At present in Alberta, our Domain IV service options are limited. Hence, people who require this level of intervention are more likely to be found in inappropriate settings or to be homeless. Developing this system capacity beyond our presently available options should be a provincial priority when implementing the proposed framework.

In order to provide a reasonable ease of access, these tertiary-level service options must be geographically balanced across the province. At first glance, this would suggest a Domain IV capacity in each of southern Alberta, central Alberta and northern Alberta. These "concurrent disorder enhanced" sites have significant potential to serve as centres of clinical and academic excellence. It would be important that these sites are developed as provincial resources offering full access to all Albertans irrespective of their community of origin.

Range of Services

A client-centred approach to concurrent disorders requires a comprehensive scope of co-ordinated addictions and mental health services. These services include health promotion, prevention, early identification, harm reduction, treatment, long-term rehabilitation and relapse prevention, community reintegration and aftercare.

Conceptual models and treatment options for addiction and mental health problems are developed as a suite of services that is easy for the person to access and to understand. Some programs would be concurrent disorder enhanced; some would be primarily mental health programs with addictions capability; and some would be primarily addictions programs with mental health capability.

The suite of service options available to this client population includes (but is not limited to) the following critical elements:

a. Information

Information is vital in promoting clients' health, building their awareness about service options, and helping them understand the nature of concurrent disorders.

Public information and awareness campaigns can also be a major factor in countering the stigma associated with both addiction and mental illness.

b. Prevention and Early Identification

Prevention and early identification are cornerstones of a service continuum. These are particularly relevant for people whose disorders are not severe enough to bring them to the attention of either the addiction or mental health treatment systems. This group is of particular concern because it is here

that service providers may have the greatest impact on reducing harm and improving overall quality of life. The service needs of children, youth and families will receive particular attention.

c. Clinical Case Management

Once the client's condition is stable, and appropriate screening and comprehensive assessment have given rise to a comprehensive treatment plan, clinical case management becomes the focus for ongoing treatment.

Case management and care are balanced with expectation, empowerment and empathic confrontation. Clients receive help with those things they cannot do for themselves because of acute impairment. At the same time, they are empowered to take responsibility for decisions and choices they need to make. When necessary, they are empathically confronted with the negative consequences of poor decisions.

d. Aftercare

A crucial element in deterring relapse is the provision of timely and effective aftercare services. Aftercare includes mechanisms for monitoring and providing opportunities for intervention before the client is in trouble. Long-standing working relationships should be maintained with clients (e.g., through regular telephone contact). The person may remain in a stable state for several months, or even years, but may then enter a period of turmoil requiring support and help in problem solving. Clients should have the capacity to access the full scope of services based on their stability, rather than delaying until the crisis is full-blown.

Building Blocks for Service Delivery

To move from where we are to where we want to be, the following building blocks for a provincial framework are required:

a. Understand the Unmet Need

Service providers must have a confident understanding of the magnitude and scope of unmet need, both in present clients and into the future. This includes the number of clients with concurrent disorders, the types and prevalence of specific disorders, and the need for service among specific subpopulations.

The federal government's interim report *Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada*[22] states, "Despite the efforts by all provinces and territories to improve the delivery of mental health services/supports and addiction treatment, a majority of Canadians suffering from mental disorders still do not seek and receive professional

[22] Standing Senate Committee on Social Affairs, Science and Technology. (2004). *Mental health, mental illness and addiction: Overview of policies and programs in Canada* [Electronic version]. Retrieved January, 2005, from www.parl.gc.ca

help." According to the 2002 Canadian Community Health Survey (CCHS), only 32% of people with mental illness and addiction had seen or talked to a health professional during the 12 months prior to the survey.[2]

A comprehensive and reliable method of identifying unmet need in both the general population and special populations, and of collecting and sharing client service information, is essential. Information from other provincial and regional jurisdictions will be valuable in determining the magnitude of demand.

b. Make Services Accessible

Particular attention needs to be focused on the challenges people face when attempting to get the support they need for recovery and good mental health. Timely access is one challenge; child care is another. Geographical access is also a challenge, particularly in some rural areas where lack of transportation can be a major barrier to reaching much-needed services. In addition, clients who must travel to reach services are separated from the informal support provided by their families and communities. Access barriers can also be created by the sometimes limited hours during which services are offered to the general public.

Both tele-health and videoconferencing offer the potential to improve service delivery to clients living in rural and remote communities.

In a co-ordinated system, mental health therapists and addictions counsellors would be able to make timely referrals to each other's services. If successful collaboration is to be achieved, time has to be built into each clinician's working schedule for professional collaboration and information exchange.

c. Address the Unique Needs of Specific Populations

The Standing Senate Committee notes, "Some population groups in Canada encounter specific access problems and receive services of diminished quality due to cultural, linguistic and geographical barriers. They include Aboriginal peoples, individuals from culturally and linguistically diverse backgrounds, and people living in rural and remote areas. The absence of culturally appropriate services and supports has had a strong negative impact on many individuals."[3]

The multifaceted nature of Canada's Aboriginal population, along with the federal, provincial and territorial jurisdictional divisions that affect this population's access to service, have created serious barriers to service delivery for Aboriginal Canadians.[4] These are further complicated by cultural factors that affect individual decision-making, such as past government policies and practices, racism, marginalization, the projection

[2] Statistics Canada. (2003, September). *Canadian Community Health Survey: Mental health and well-being 2002*. Available from www.statcan.ca

[3] Standing Senate Committee on Social Affairs, Science and Technology. (2004). *Mental health, mental illness and addiction: Issues and options for Canada* [Electronic version], p. 7. Retrieved January, 2005, from www.parl.gc.ca

[4] Standing Senate Committee on Social Affairs, Science and Technology. (2004). *Mental health, mental illness and addiction: Issues and options for Canada* [Electronic version], p. 13. Retrieved January, 2005, from www.parl.gc.ca

of an inferior self-image, habits of dependency, and a critical shortage of adequately trained Aboriginal mental health and addictions professionals.

According to the Canadian Community Health Survey[20], adolescents and young adults (15 to 24 years of age) are "the least likely of all age groups" to access mental health or addiction resources, even though they have higher rates of mental disorders. Reasons for this disparity include a general lack of awareness of services, the stigma attached to mental illness, and limited availability of appropriate services.

Seniors with mental illness and addiction are another particularly vulnerable segment of the population. Many seniors mistakenly believe that problems such as depression or cognitive impairment are part of the normal aging process and that no effective treatments are available. Mental illness in seniors may be masked by concurrent disorders that can make accurate assessment and treatment particularly difficult.

This highlights the need for mental health and addiction professionals who are specialized in the care of seniors, including those who reside in institutional settings. There is limited published research specifically addressing best practices in mental health for seniors. Best practice guidelines are needed to guide care providers who are called upon to manage simultaneous and multiple health issues in our aging population.[21]

Family members and significant others are often the principal resource and the sole support available to people whose lives are affected by mental health issues and addictions. The support provided to family caregivers is often limited, and is geared primarily to the needs of the affected person rather than to the needs of family members or significant others. There is a need to provide a co-ordinated range of supports to family caregivers and significant others. The economic value of doing this is potentially enormous.

Employees are another special population. Employers can play a vital role in dealing with addiction and mental illness among workers, in the form of disability management, accommodation policies and return-to-work programs. An organization's internal culture can make a huge difference in how mental illness and addiction are addressed in the workplace.

d. Articulate the Role(s) of the Various Service Providers

Each organization's unique contribution to serving this population must reflect its strengths and capacities, must be clearly understood by partner providers and their staff, and must be articulated in a consistent manner through a wide variety of venues. Decisions about harm reduction and abstinence need to be clarified within the interagency teams of service providers.

[20] Statistics Canada. (2003, September). *Canadian Community Health Survey: Mental health and well-being 2002*. Available from www.statcan.ca

[21] Standing Senate Committee on Social Affairs, Science and Technology. (2004). *Mental health, mental illness and addiction: Issues and options for Canada* [Electronic version], p. 15. Retrieved January, 2005, from www.parl.gc.ca

It is well recognized that more addiction and mental health care is provided outside of the formal treatment systems than from within. Sully[7] notes that primary care providers including physicians, psychologists, social workers and nurses, as well as a range of counsellors in private offices and hospital emergency departments, deliver the bulk of mental health care. In addition to these, we might add self-help groups such as the Schizophrenia Society, Alcoholics Anonymous and Narcotics Anonymous, clergy, teachers, employee assistance advisors, police officers and a host of community resources to the list of those who deliver informal addictions care and support.

With that in mind, the contribution of formal service providers such as Alberta Children and Family Services, Justice and Education needs to be formally incorporated into the framework of service. As well, the role of the variety of informal service deliverers needs to be recognized and celebrated.

The evolving roles, mandates and perspectives of various service providers must be kept in mind. For example, mental health services have traditionally been diagnosis-oriented with access to pharmaceuticals, whereas addictions services have traditionally been behaviour-oriented (although these approaches are gradually shifting). At the same time, agencies will need to be prepared to step outside of their traditional mandates from time to time in response to the presenting needs of the client.

e. Refine Screening and Assessment

A significant challenge to collaborative care is a shared understanding of each agency's screening and assessment protocols, and a shared understanding of the language. Where possible, the use of common screening instruments would assist providers in determining the primacy of a person's mental health and substance abuse issues, and in recognizing the need for and timing of effective treatment interventions and follow-up.

For example, many psychiatric symptoms may decrease in number and intensity with a reduction in substance use. Consequently, for some clients, sobriety for several weeks may be the initial step in an effective treatment plan.

Health Canada's Best Practices recommends that all people seeking help from mental health treatment services be screened for co-occurring addictions, and that all people seeking help from addictions treatment services be screened for co-occurring mental health disorders. Health Canada identifies the purpose of screening as "not to determine the complete profile of psychosocial functioning and needs, or to make a diagnosis; but rather to identify whether the individual may have a mental health or substance abuse problem that warrants more comprehensive assessment."[8]

[7] Sully, P. (2003). *Joint Alberta Mental Health Board/Calgary Health Region evaluation project: Shared mental health care service*. Calgary, AB: Alberta Mental Health Board & Calgary Health Region.

[8] Health Canada. (2002). *Best practices: Concurrent mental health and substance use disorders*. Ottawa, ON: Author.

As part of developing capacity to serve this client population, an encouraging model has been developed by the American Society for Addiction Medicine (ASAM). ASAM's Patient Placement Criteria[30] presents six assessment dimensions encompassing pertinent biopsychosocial aspects of addiction that determine the severity of the client's disorder and level of function:

- Acute Intoxication and/or Withdrawal Potential
- Biomedical Conditions and Complications
- Emotional, Behavioural or Cognitive Conditions and Complications
- Readiness to Change
- Relapse, Continued Use or Continued Problem Potential
- Recovery/Living Environment

Appropriate intervention and support is defined by biopsychosocial severity, as well as the extent and severity of problems in all six of ASAM's assessment dimensions.

Comprehensive, multidisciplinary involvement in the assessment process is a prerequisite to quality care. In particular, the role of primary care physicians in the assessment process needs to be clarified.

At the same time, provision must be made for people requiring specialized mental health and/or addictions assessment.

f. Implement a System of Shared Care

Overall, the literature shows that a case-managed approach improves outcomes for people with a variety of serious and chronic illnesses, including addictions and mental illness. Substance abuse clients in particular have improved treatment outcomes when their problems are addressed holistically.

Clients with concurrent disorders who receive case-managed care are more likely to remain engaged in services longer than clients who do not receive case-managed care.[31] Concurrent disorder clients receiving case management in residential detox are more likely to transition successfully to another level of care within 30 days of discharge, compared with clients not receiving case management.[32]

For those agencies using a case-management approach, case manager responsibility would be assigned at the client's first point of entry into the formal treatment system. A case-managed approach would contribute

[30] American Society of Addiction Medicine. (2001). *ASAM patient placement criteria for the treatment of substance-related disorders* (Rev. 2nd ed.). Chevy Chase, MD: Author.

[31] Schwartz, M., et al. (2002). *The effect of case management in substance abuse treatment: Analysis of special populations*. Retrieved November, 2004, from http://www.icpsr.umich.edu/SAMHDA/NTIES/NTIES-PDF/REPORTS/HAR_final.pdf

[32] Schwartz, M., et al. (2002). *The effect of case management in substance abuse treatment: Analysis of special populations*. Retrieved November, 2004, from http://www.icpsr.umich.edu/SAMHDA/NTIES/NTIES-PDF/REPORTS/HAR_final.pdf

significantly to ensuring that clients are actively engaged in developing a treatment plan that reflects their unique needs and wishes, ensuring input from the treatment team, and ensuring that the services offered are most appropriate for each client's current and emerging unmet health service needs.

This model of shared caring has the potential to be expanded beyond addiction and mental health service providers. In some situations, the logical case manager may be situated in a service other than mental health or addiction services. Case managers have the potential to liaise with a variety of human service agencies. Expansion of such a model to a broader audience of service providers would require consultation with the human service agencies involved before any conclusive statements could be offered.

The role of the primary case manager is a key factor for the success of this framework. In instances where a case manager is required, a consistent approach across systems will be imperative for client success. For example, what are the consequences if a client misses an appointment, is consistently late, or arrives for an appointment under the influence of alcohol or other drugs? Although questions such as these may seem trivial, they are important issues in the daily management of one service, let alone for two or more services working with the same person. Managers and clinicians across agencies must be prepared to address these sorts of dilemmas if the service is to improve individual outcomes.

With a view to moving case management from theory to practice within AADAC, the commission's Concurrent Disorders Task Group is reviewing the variety of models available both in the literature and in practice, to articulate the pros and cons of various models and to propose a framework for determining an effective case-management approach.

No matter which case-managed approach is used, the essential element is that the person has a single point of reference with the formal treatment system. This ensures that the various aspects of his or her treatment and recovery plan are co-ordinated, and that navigational advocacy is available when it is required. Appropriate referrals to providers who can address the person's unmet needs, and timely follow-up, are essential to positive treatment outcomes. This includes sensitivity to the person's socioeconomic circumstances.

g. Ensure a Range of Flexible, Person-Centred Treatment Options

Once the person's unmet needs are identified, staff require the tools to ensure that they are appropriately addressing those assessed needs. As a prerequisite to effective treatment, the capacity must exist to exchange relevant clinical information and to modify standardized treatment regimens in response to individual needs.

Treatment approaches must be flexible enough to address the needs of the person within the resources and options available to the local provider. People who have concurrent disorders may not choose to participate in, or may not benefit from, the same programs as those provided for other people. Optional approaches need to be available, and people should not be stigmatized or made to feel isolated as a result.

As one example, the literature reports a variety of studies indicating that with people who have a partner, counselling intervention with the couple is more effective than counselling with the person alone. While fully acknowledging the benefits of familial support, it is also recognized that the people in the client's immediate environment may unknowingly reinforce addiction patterns and neurotic behaviours. The choice of a healthy social support system, and particularly that of a romantic relationship, is often the most difficult personal competency to achieve. With that in mind, it is worth noting that although significant others can be a strength, they can also be part of the problem. To work with them may transform a client liability into a client asset.

People should be informed of the potential interaction between their medications and illicit street drugs or alcohol. This population may also be at special risk of "double-doctoring" so this possibility should be monitored.

As another example of the range of treatment options, longer-term residential care is an essential component in a treatment continuum, because this population has significant potential to lack even basic social supports, and because relapse is often complicated by drug and medication use behaviour that occurs after the immediate episode has passed.

h. Develop an Inventory of Staff and Program Capacity

Throughout the province, there are a number of staff from addictions offices, residential treatment sites and mental health clinics, and physicians who are confident and capable when working with people who have concurrent disorders. Their shared wisdom will be invaluable as we seek to build collective capacity.

In light of traveling distances and relatively low population density in some areas of the province, mental health and addiction services are often lacking in remote areas, including Aboriginal communities. There is need for clinical case consultation, including a potential role for tele-psychiatry for support and advice with difficult cases.

i. Identify Required Staff and Program Competencies

The system will need a clear idea of the level and scope of support required by people whose lives are affected by addictions and mental illness, of the expectations regarding the specific services that it is able to deliver, of the staff competencies required, and of the services it is not able to deliver at this time.

Professionals from a variety of disciplines are involved in delivering addiction and mental health services. They include social workers, psychologists, nurses, addictions counsellors, primary care physicians, psychiatrists, and many others. A provincial human resource strategy would assist in optimizing their contribution. The objective of such a strategy should be to ensure that the right services are delivered in a culturally appropriate, least intrusive manner by the right person with the right skills at the right time.[1]

As well, by acknowledging that more addiction and mental health care is provided outside of the formal treatment systems than from within, we can seek ways to ensure that we are using those external resources to their fullest potential, and providing support where necessary.

j. Ensure Secure but Accessible Clinical Information

Sharing relevant clinical information is essential to delivering a seamless service for this client population. A mutually agreed-upon protocol is needed for ensuring client confidentiality and obtaining informed client consent to collect and share information. Such a protocol must fully protect the client's right to privacy, while supporting the service provider's need for relevant information required for informed clinical decision-making.

Such a protocol has the potential to eliminate multiple-intake procedures, which can be frustrating for clients and inefficient for staff.

k. Develop a Collective Wisdom

Health professionals must have the knowledge and skills to respond appropriately to the unmet needs of clients and their families whose lives are affected by addictions and mental illness. Both pre-service and in-service education and training of health professionals in all disciplines is fundamental to identifying and appropriately treating or referring people who have a concurrent disorder. This includes training clinicians who do not specialize in mental health or addictions, but who see a broad spectrum of patients and clients.

To prepare tomorrow's workforce, the current status of health professional training in concurrent disorders should be examined and, where required, strategies should be developed for improving clinicians' knowledge, skills and confidence. Training should include information on evidence-based principles of universal, targeted and indicated prevention strategies; screening protocols; methods of intervention; treatment initiation; referral; and linking with other clinicians and services to provide a holistic approach to client care. Because core curricula in the health professions are strongly influenced by licensing examinations and certification requirements,

[1] Standing Senate Committee on Social Affairs, Science and Technology. (2004). *Mental health, mental illness and addiction: Issues and options for Canada* [Electronic version]. Retrieved January, 2005, from www.parl.gc.ca

partnerships with professional associations and academia will be fundamental to addressing training needs.

Formal academic course work provides a context, not a substitute, for hands-on experience. A blend of academic and practical knowledge will be essential for a well-prepared workforce.

In particular, addictions counsellors and mental health therapists need a basic understanding of each other's disciplines in order to be effective with people who have concurrent disorders. This includes strategies such as delineated competencies, formal course work, field placements, job-shadowing and mentorship opportunities. However, understanding alone does not equal expertise in the other field. To be effective, professionals in both fields must have enough knowledge and experience to know what they don't know, and to seek appropriate advice when the situation requires it. To that end, clear expectations regarding clinical supervision will be essential.

The process for achieving universal concurrent disorder capable competency among addiction and mental health clinicians will require a balance between provincial direction and regional implementation. One approach to implementation would be to develop a network of front-line clinicians who would provide ongoing staff support and training, translate initiatives at the level of clinical practice, and provide feedback from clinicians regarding required changes.

Training efforts would also include large-scale training opportunities aimed at developing the knowledge base needed to foster a systemic vision, and to build competency into routine program activities. Distance learning and online instructional technology provide tremendous opportunities for advancing collective wisdom.

In addition to this system-wide generalist knowledge, it may be useful for a specific group of professionals to be formally cross-trained and fully credentialed in both fields in order to serve those who require an enhanced level of service as defined in ASAM's approach.

Developing a collective wisdom should not be limited to addictions counsellors, mental health therapists and physicians. Though the primary health-care system is often the first point of contact for people affected by mental health disorders or addictions, primary health-care providers may lack sufficient knowledge, skills and resources to screen clients and to facilitate appropriate referrals. Access through the primary health system could be improved for clients with mental illness and addictions by increased professional awareness, opportunities for education and training, and collaborative clinical initiatives.

Self-help groups such as Alcoholics Anonymous and Narcotics Anonymous, community resources such as Alberta's Schizophrenia Society, clergy, teachers, employee assistance advisors, police officers and other community-based support services are also pivotal in addressing the needs of those

whose lives are affected by addiction and mental illness. Like primary health-care professionals, community service providers require awareness and training to effectively intervene with and refer individuals.

l. Build Relationships

A collaborative system of care depends on strong relationships between service providers at all levels: community, regional and corporate. Collaboration stems from knowing each other, trusting each other and learning to appreciate different points of view.

m. Develop Interorganizational Centres of Excellence

Centres of excellence would provide a forum for training, research and clinical activities related to specific topic areas. Examples of topics might include brief prevention and intervention in the primary health setting, children and families, older adults, maternal and child health, and clinical practice standards for primary health providers. These centres would provide opportunities for interdisciplinary and interorganizational collaboration in curriculum development, clinical practice, research and the translation of research into practice, policy analysis and formulation, and networking to advance knowledge and practice.

"Concurrent disorder enhanced" sites, capable of serving people whose needs are consistent with Domain IV of the proposed schema, have significant potential to serve as centres of clinical and academic excellence. It would be important that these sites be developed as provincial resources offering full access to all Albertans, regardless of their home community. In order to provide reasonable ease of access, these tertiary-level service options must be geographically balanced across the province. At first glance, this would suggest a Domain IV capacity in each of southern Alberta, central Alberta and northern Alberta.

n. Ensure Sustainability

To address gaps and fragmentation in the mental health and addiction treatment systems, sufficient resources are required to provide a basic scope of services and supports.

To realize longer-term efficiencies through improved client outcomes, both the mental health system and the addictions system will require additional resources if they are to fully implement a system of shared care. In the short term, there is not sufficient "stretch capacity" in the existing system.

What is the right amount to spend on this suite of services? A starting point would be to develop a system of population-based capacity targets and indicators for each service type, from which to articulate funding requirements. This is a longer-term initiative that merits consideration.

o. Promote Clinical and Programmatic Research

Canada does not collect data on an ongoing basis on the prevalence of mental illness and addiction in either the general population or among specific groups within that population (e.g., homeless, Aboriginal peoples, women, children and adolescents). Informed decision-making and client outcomes both have the potential to be improved by a national information database and a national research agenda, combined with increased funding and support for basic and applied research on mental health and addiction issues; evaluation of policies, programs and services; and the transfer of knowledge from research to practice.

A research agenda would build on current Canadian and Alberta expertise, co-ordinate research activities performed by a variety of participants, and ensure a balance among biomedical, clinical, population health and service delivery research applied to mental health and addictions.[1] Conducting both quantitative and qualitative research to inform practice is essential.

Transferring this research into practice is critical to developing service capacity. The translation of an idea or discovery into an accepted practice has three distinct phases.[2] The first is the basic discovery that identifies a new method of delivering care, a new way of engaging clients in therapy, or a new genetic association. The second phase is proof-of-principle, which involves translating the idea into care and demonstrating that it works in a controlled setting (i.e., the clinical trial phase). The third phase, system-wide dissemination and application, involves incorporating the practice into the existing scope of services. Each of these phases requires significant commitment, and each presents unique challenges.

p. Monitor Performance and Ensure Accountability

Evaluating effectiveness and ensuring consistency with best practice are precursors to developing and maintaining a system of services. To that end, a performance evaluation system is needed to monitor the quality and effectiveness of programs and services available for people with concurrent disorders. This includes ensuring adherence to established best practices, and achievement of accepted system and service performance indicators. An accountability framework should be developed to monitor overall system productivity.

q. Share Success Stories

In Alberta, we have a number of real-life examples of successful partnerships in delivering services to this population. Many of these collaborations have

[1] Standing Senate Committee on Social Affairs, Science and Technology. (2004). *Mental health, mental illness and addiction: Overview of policies and programs in Canada* [Electronic version]. Retrieved January, 2005, from www.parl.gc.ca

[2] Standing Senate Committee on Social Affairs, Science and Technology. (2004). *Mental health, mental illness and addiction: Overview of policies and programs in Canada* [Electronic version], p. 227. Retrieved January, 2005, from www.parl.gc.ca

been in place for more than a decade. Initiatives and partnerships such as these must continue to be developed, corporately supported and used as models for others to emulate.

Implementation

Before the strategy can be implemented, there are multiple levels of operational decisions to be made at the provincial, regional and community levels. The provincial strategy is intended to provide regional and local decision-makers with the flexibility to apply the framework in a way that best responds to the unique circumstances in individual communities.

As a part of its provincial consultation, AADAC and most health regions identified implementation opportunities and committed these opportunities to action plans, for rollout over the next 6 to 12 months. These next-step action plans address specific "building block" challenges of greatest mutual interest, with a view to building on the momentum the consultations generated.

This momentum is already evidenced within AADAC. For example, the commission is refining its client intake process to ensure that all clients are screened for the presence of a concurrent mental health issue. In addition, the AADAC Concurrent Disorders Task Group is reviewing the variety of case-management models available both in the literature and in practice, to articulate the pros and cons of various models and to propose a framework for determining an effective case-management approach. These initiatives will enhance AADAC's capacity to effectively collaborate with partners in both addiction and mental health services.

The provincial consultations also confirmed a growing consensus that building on the strength of existing relationships between AADAC and health regions will enhance our provincial health system's capacity to support this client population in their recovery. Examples of enhanced capacity initiatives would include greater ease of access to services, informed cross-organizational client consent, strengthened clinical interface (e.g., co-facilitated treatment groups), case conferencing, exchange of training opportunities, and case-management demonstration projects.

It is fully acknowledged that system change does not happen overnight. Shifts in the way systems conduct their business can endure only when they are embraced gradually, through an evolutionary process. Any change process must be accepted as evolutionary, nonlinear, and requiring time and patience.

AADAC and AMHB are considering the potential contribution of a Provincial Implementation Advisory Committee. This committee would contribute clinical and administrative advice on implementation activities, recommend system performance measures, support local and regional

initiatives, and provide a forum for identifying issues and opportunities, and building support related to specific demonstration projects and initiatives.

The existing health region/AADAC short-term plans are an excellent starting point for the detailed operational decision-making required for regional and local implementation. For this initiative to be successful, ownership at the local level is critical. AADAC and mental health offices will need to develop close relationships at the field level, supported by management and organizational policies.

There may be merit to a staged approach – starting, for example, with informal co-ordination activities and information sharing among health region and AADAC managers and staff, then expanding to include a broader group of stakeholders (clients and their advocates, justice system, housing, child welfare, public health, employment services, etc.). The primary goals of interacting with some stakeholders may be simply to provide information and build relationships. Dedicated resource people should be in place to support the process.

In addition, performance measures should be developed for universal implementation across the province. These should include best practice expectations, and might include such expectations as each partner agreeing to

- "welcome" existing clients with concurrent disorders as part of formal policy and practice
- implement universal integrated screening and identification practices
- develop the capacity to accurately measure the prevalence of concurrent disorders in its service population
- commit to evaluating its current status of concurrent disorder competence, and develop its own quality improvement plan to achieve concurrent disorder capability
- commit to working together to introduce a client information release process that is respectful of the client's right to privacy, and the clinician's need for relevant clinical information
- commit to providing timely referral and consultation support, and participate in routine case conferencing activities
- ensure that each clinician is provided with an expected scope of practice and desired core competencies for concurrent disorder treatment, and has a training plan for achieving those competencies

Given its provincial mandate, AADAC is prepared to take a lead role in working with health regions, the Alberta Mental Health Board and consumer representatives to develop these performance measures. This may be an appropriate role for the Provincial Implementation Advisory Committee.

As a part of developing performance measures, a series of incentives will be essential to jump-start activities at the local level and to ensure that all areas of the province maintain the momentum toward fully implementing the provincial framework for this client population. This could include such support as consultation at the system and program level, formal technical assistance, access to training, demonstration project funding and infrastructure support.

Individual health regions and AADAC have already initiated a number of exciting service partnerships. AADAC will also be working with health regions to develop a number of demonstration projects in 2005-2006. These projects will focus on building system capacity. Demonstration sites will provide tangible evidence of the value of a collaborative approach to serving the needs of this client population. Projects will be planned, implemented and evaluated in a way that creates a sense of collective ownership by all partners.

In almost every health region, sharing relevant clinical information was identified as a cornerstone to delivering a seamless service for this client population. With this in mind, AADAC worked with legal counsel in Alberta Justice to develop a proposed shared client consent form to collect and disclose confidential information between AADAC and individual health regions across the province.

This consent and disclosure form was drafted with a view to

- fully protecting the client's right to privacy
- satisfying the various requirements of the Freedom of Information and Protection of Privacy Act, the Health Information Act and the Alberta Alcohol and Drug Abuse Act
- supporting the service provider's need for relevant information required for informed clinical decision-making
- limiting disclosure to those employed or engaged by AADAC and the health region who are responsible for or involved in providing the client with continuing treatment and care, or with other services provided by AADAC or the specific health region

This proposed shared consent form is being implemented through discussions with individual health regions. As part of the system's evolution, there may be value in revisiting this consent and disclosure process to include other specified service providers.

Conclusion

This framework provides a road map for implementing a system of shared care for serving Albertans affected by concurrent substance abuse or gambling problems and mental health issues. The goal for all partners should be to provide people whose lives are affected by additions and mental health issues with early access to continuous treatment that can be maintained over time, and that is not limited to any particular setting or locus of care. To achieve that goal will require provincial leadership and direction coupled with flexible application at the regional and community level.

Ultimately, the focus of any model of service delivery for people with concurrent disorders should be on ensuring that their needs are addressed in a co-ordinated, collaborative and seamless manner. As Health Canada's Best Practices states, it is through synergy—a dedicated commitment from all partners—that the complex needs of this population will be addressed both in the short term and into the future.

Appendix A: Shifting Perspectives

The Current Situation

Both the mental health system and the addiction system have experienced challenges dealing with a mental illness and an addiction at the same time. The reasons for this include differences in treatment philosophies, approaches to service delivery, and screening/assessment processes, as well as inequities in staffing and resources.

Addictions counsellors and mental health therapists are not usually trained in each other's disciplines. At times, there is a lack of knowledge about the other discipline's unique expertise and what the other system does.

In addition, there is still a great deal of stigma regarding both addiction and mental illness. People who have a mental health disorder are reluctant to be labelled as having a substance abuse problem, and vice versa. Addiction service clients are often reluctant to disclose their association with mental health services. Similarly, mental health service patients are often reluctant to disclose their involvement with an addiction service, the abuse of substances or a gambling problem.

People with concurrent disorders tend to experience multiple medical and social problems, they tend to be more symptomatic, and they tend to require more expensive care. They are at advanced risk of incarceration and homelessness, and significant numbers are HIV-positive.[1]

These people are also at serious risk of being disproportionately affected by lack of access to services, which tends to contribute to reduced health as compared with that of others in our society. They are at increased risk of being socially excluded and may experience obstacles when it comes to the challenges of housing, employment, income, insurance, education, criminal justice and parenthood. They may be treated differently, or overtly discriminated against, and may be unable to gain access to required services and supports.

Geppert and Minkoff[2] report that "this population has worse treatment outcomes, higher health care utilization, increased risk of violence, trauma, suicide, child abuse and neglect and involvement in the criminal justice system, more medical co-morbidity, particularly infectious diseases, and higher health care costs than people with single disorders." They are also more likely to experience homelessness, higher family burden and greater relapse rates than people with a single disorder.

[1] Substance Abuse and Mental Health Services Administration. (1997). *Addressing the needs of homeless persons with co-occurring mental illnesses and substance abuse disorders: An innovations technical assistance package*. Rockville, MD: Author.

Geppert, C. M. A., & Minkoff, K. (2004, April). *Issues in dual diagnosis. Diagnosis, treatment and new research*. Psychiatric Times, 21(4), 103-107.

Kessler (1996) reported that people presenting with a substance abuse problem and a psychiatric diagnosis tended to access services more frequently, which may suggest that the distress caused by a mood or anxiety disorder is one of the primary motivators to seek help in addiction treatment settings.[39]

When they do seek help from the formal addiction and mental health systems, there are often no shared screening and assessment tools to confirm the precise nature and extent of the concurrent disorders. This makes treatment planning especially challenging; faced with the complex task of discerning the meaning of multiple symptoms independent of one another, service providers often arrive at different conclusions about similar symptoms.

Differences in counsellor/therapist knowledge of best practices may also create a barrier to effective treatment. For example, the belief that mental health issues must be fully addressed prior to addiction treatment (and vice versa) can be a barrier for the person who is seeking care.

Canada's health system has a history of limited co-ordination and often competing perspectives between the addictions and mental health systems.[40] Each system has tended to view clients in single-problem mode—either as mentally ill, or dependent on alcohol or other drugs. As an attempt to address this problem, "program treatment integration" for people with concurrent disorders arose in the 1980s.[41]

The term "program treatment integration" is used when

> mental health treatments and substance abuse treatments are brought together by the same clinicians/support workers, or team of clinicians/support workers, in the same program, to ensure that the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers.[41]

Service System Considerations

Recognizing the high prevalence of co-occurrence, Shapiro cautions against any tendency to combine addictions and mental health disorders as if they were a single condition. He stresses that they are two different primary diseases—different brain disorders—with different treatment approaches and different expectations of outcomes.[42]

[39] Room, R. (1998). *The co-occurrence of mental disorders and addictions: evidence on epidemiology, utilization and treatment outcomes* [Electronic version]. Retrieved August, 2004, from http://www.bks.no/co-occur.pdf

[40] Health Canada. (2002). *Best Practices: Concurrent mental health and substance use disorders*. Ottawa, ON: Author.

[41] Drake, R. E., & Meuser, K. (2000). Psychosocial approaches to dual diagnosis. *Schizophrenia Bulletin, 26*(1), 105-118.

[41] Health Canada. (2002). *Best Practices: Concurrent mental health and substance use disorders*. Ottawa, ON: Author.

[42] State Association of Addiction Services. (2004). *Testimony to the committee on crossing the quality chasm-Adaptation to mental health and addictive disorders* [Electronic version]. Retrieved December, 2004, from http://www.saasnet.org/Resources/IOM%20Testimony%209-14-04.pdf

In its report to the United States Congress,[i] the Substance Abuse and Mental Health Services Administration (SAMHSA) reminds us of two facts around which a service system needs to be structured:

1. People who have concurrent disorders need to be treated in a holistic, rather than a condition-specific, manner.

People with concurrent disorders have lives and families, hopes and dreams, responsibilities and needs. Coming from all walks of life, they may also have HIV/AIDS, be victims of physical or sexual abuse, be homeless, or be involved with the criminal justice system. Too often, these people pay a high price for having concurrent disorders: lost dreams, lost families, and in some cases, lost lives. To be effective, service interventions need to be individualized, person-centred and results-driven.

In other words, treatment strategies for this population must be comprehensive (first addressing the client's most pressing life circumstances), co-ordinated and, most specifically, person-centred.

2. Concurrent disorders are both common and complex.

As is the case with addictions and mental health problems alone, no single concurrent disorder defines all people who experience it. Both addictions and mental illness are complex, with a variety of biological, psychological and social components.

Concurrent disorders are not a single condition. They include a vast array of addiction and mental health issues that vary by their underlying causes, their presenting symptoms, the degree of impairment they cause, the extent to which people affected are motivated to address their problems, and the service types required (ranging from voluntary participation to mandatory confinement). Compulsory hospital admission and psychiatric treatment are often required to enable people who refuse voluntary treatment to address the consequences of their untreated mental illness.

Dr. Ken Minkoff states that individuals presenting with concurrent disorders should be the expectation, not the exception, in the substance abuse and mental health treatment systems. The literature supports the belief that both conditions must be addressed as primary, and treated as such.[ii] A further reality is that a person with a mental health issue is at increased risk of misusing substances, just as a person with an addiction is at increased risk of developing a mental health problem, or having an existing disorder made worse.

[i] Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders*. Rockville, MD: Author.

[ii] Drake, R. E., McLaughlin, P., Pepper, B., & Minkoff, K. (1991). Dual diagnosis of major mental illness and substance disorder: An overview. In K. Minkoff and R. E. Drake, (Eds.), *Dual diagnosis of major mental illness and substance disorders* (pp. 3-12). San Francisco, CA: Jossey-Bass.

Krausz[9] suggests four categories of concurrent disorders:

- a primary diagnosis of a major mental illness with a subsequent secondary diagnosis of substance abuse which adversely affects mental health
- a primary diagnosis of drug dependence with psychiatric complications leading to mental illness
- a concurrent substance abuse and psychiatric disorder
- an underlying traumatic experience resulting in both substance abuse and mood disorders (e.g., post-traumatic stress disorder)

Crome[10] asserts that the nature of the relationship between mental health disorders and substance abuse is complex for a variety of reasons:

- Substance use and withdrawal from substances may lead to psychiatric syndromes or symptoms
- Intoxication and dependence may produce psychological symptoms.
- Substance use may exacerbate or alter the course of a pre-existing mental health disorder
- A primary mental health disorder may precipitate substance abuse, which in itself may lead to psychiatric syndromes

The Shift Toward Collaborative Systems

In recent years, there has been a groundswell of support for a multi-agency approach—a systemic approach—to respond to the needs of people with concurrent addiction and mental health issues. It is now accepted that no single care system is sufficiently equipped in resources, training and service capacity to provide the full scope of services required.

With a greater understanding of the limitations of individual service systems, a broader perspective towards the treatment of concurrent disorders has evolved—one that recognizes the need for psychological and social support services, acute treatment, medication management, symptom reduction, spiritual support and leisure counselling. There is also acceptance that support may be needed in other human service areas such as housing, vocational training and employment, family counselling and social networks. No single service system has either the capacity or the knowledge to provide all of these supports. Nor would it be a wise investment of resources to specialize and congregate these diverse services within a single organization. As a result, a shift towards a collaborative systems approach has emerged.

[9] Krausz, M. (1996). Old problems-new perspectives. *European Addiction Research*, 2, 1-2.

[10] Crome, I. B. (1996). *Psychiatric disorder and psychoactive substance use disorder: Towards improved service provision*. Unpublished manuscript.

System collaboration is not without its challenges. Because of the nature of concurrent disorders and their symptoms, people in need of treatment are likely to appear in a variety of settings, including addiction services, mental health services, hospital emergency departments, physicians' offices, the justice system, child and family services, juvenile services and educational settings. Each of these systems functions independently, and each taps into intersystem linkages and community resources to varying degrees. Less than effective interaction among systems may interfere with their collective capacity to provide high-quality care.

Inadequate resources are often cited as the reason for deficiencies in the treatment system. The reality is that resources are often available but underused. Intersystem linkages that match care to need, and improved access to services regardless of point of entry, are crucial if we are to increase our capacity for positive client outcomes.[47]

Well-organized and linked care systems can expand the power of individual treatment programs. They can provide effective pathways for clients to move between services, and they can help clients make the transition from active treatment to less intrusive community-based support systems.[48]

The collaborative systems approach has three main goals: client attraction, engagement and retention.[49] A collaborative systems model needs to accommodate multiple co-existing disorders whose severity may change over time. It must also be adjustable to shifts in the client's level of social stability and commitment to address underlying causes. With that in mind, treatment services need to be flexible and tailored to the needs of each client.[50] There must be a mutually agreed-upon and well-communicated treatment plan, and a consistent, co-ordinated implementation of that plan.[51]

Programs must be attractive and non-threatening, with evidence of respect for the client and the assurance of confidentiality.[52] Policies must be in place to ensure equity of access and service intensity. Prevention, screening, early intervention, ongoing assessment, treatment, relapse management and aftercare are all elements of a comprehensive framework.

[47] Center for Substance Abuse Treatment. (2000). *Changing the conversation*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[48] U.S. Department of Mental Health and Human Services. Substance Abuse and Mental Health Services Administration (SAMHSA). 2003. p.i

[49] The Community Recovery Network. (2001). *Barriers to treatment*. Retrieved November, 2004, from http://www.communityrecovery.org/Barriers%20to%20Treatment.htm

[50] Kavanagh, D. J. (2000). *Treatment of comorbidity*. Canberra, Australia: National Comorbidity Project. National Workshop Agenda Papers.

[51] Health Canada. (2002). *Best practices: Concurrent mental health and substance use disorders*. Ottawa, ON: Author.

[52] Health Canada. (1995). *Roundtable discussion to develop increased awareness and understanding of issues common to mental health and substance abuse*. Ottawa, ON: Author.

To address these challenges, a collaborative initiative links services across several different systems of care. Partnerships need to be strengthened or forged with

- criminal justice system
- legal services
- social and family support services
- general health-care services
- child and adult protective services
- municipal, provincial and federal services
- Aboriginal health and social services
- vocational rehabilitation services
- housing agencies
- agencies for homeless people
- educational systems
- HIV/AIDS prevention and treatment services

While recognizing that collaboration both between and within systems is needed to address the needs of the concurrent disorder population, we should not overlook the fact that primary involvement rests with mental health services and addictions services. Both of these systems must be actively engaged in building and improving linkages.

Appendix B: Models and Approaches

Health Canada's *Best Practices: Concurrent Mental Health and Substance Use Disorders* seeks to define the model of interagency linkages required to improve client outcomes. The report defines system integration as

> the development of enduring linkages between service providers or treatment units within a system, or across multiple systems, to facilitate the provision of services to individuals at the local level. Mental health treatment and substance abuse treatment are, therefore, brought together by two or more clinicians/support workers working for different treatment units or service providers. Various co-ordination and collaborative arrangements are used to develop and implement an integrated treatment plan.[1]

The report's authors identify several ways in which systems can be integrated.[2] With that in mind, and seeking to build upon the strengths of Alberta's health system, a number of international approaches were examined.

British National Health Service

The British National Health Service's national framework for the commissioning of adult treatment for drug abuse[3] provides a starting point for systems development. This framework recognizes that no model of service provision has been found to be the single most effective in managing the needs of this client group. In its report, the National Health Service identifies three common approaches to service delivery, as well as the potential limitations of each model. A summary is provided on the following page:

[1] Health Canada. (2002). *Best practices: Concurrent mental health and substance use disorders*. Ottawa, ON: Author.

[2] Health Canada. (2002). *Best practices: Concurrent mental health and substance use disorders*. Ottawa, ON: Author.

[3] National Health Service, National Treatment Agency for Substance Abuse. (2002). *Models of care for the treatment of adult drug misusers*. London, England: Author.

MODEL OF TREATMENT	DESCRIPTION	PROBLEMS / DIFFICULTIES
Sequential Treatment Model	Treatment programs are provided consecutively by mental health services and substance abuse services depending on the presenting problem	Communication between the services is limited Health problems are treated as separate entities Clients are shunted between the two services Treatment focuses on the condition rather than on a holistic approach to client care
Parallel Treatment Model	Client care is provided by both services concurrently, facilitated by communication between the two services	Clients continue to be shunted between the two services Health problems continue to be treated as separate entities Client case responsibility is not clearly defined
Integrated Treatment Model (Minkoff and Drake, 1991)	Client care is delivered by a single provider	Isolated from mainstream services[1] Approach views the concurrent disorder as a static condition Potential bottleneck, due to individual unit capacity, rather than a dynamic service Specialized service, requiring co-jointly trained staff and service specialties, tends to be an expensive service option Clinical specialties, where they exist, tend to become isolated resulting in job dissatisfaction and lack of current knowledge

The National Health Service proposes that a fourth model is more reflective of current thinking in the field. In this model, the Joint Liaison/Collaborative Model, treatment responsibility is jointly managed by both services with one primary case manager. The benefits of such an approach are

- collaboration between mental health and addiction services
- shared responsibility
- appropriate use of skills and expertise in both areas of health care
- ongoing peer support for clinical specialties
- multiple and co-ordinated points of access into the service continuum

[1] Integration and segregation refer respectively to practices or structures that maximize or limit a person's potential participation within the mainstream of society. Program structures and operations can profoundly affect the reintegration of clients back into mainstream society, particularly those who have been marginalized or are considered to be deviant in some aspect of their behaviour. A fully integrated model would require a specialized service somewhat removed from the mental health and addictions services available to mainstream society. With that in mind, this model has potential for significantly segregative outcomes for its target population. The effects of a segregated approach have been experienced in Canada and elsewhere by other client populations (e.g., the mentally challenged population and Aboriginal people).

The Joint Liaison/Collaborative Model is based on the principle that the community's services come together, wrapping around the client in a way that complements the strengths of the client and his or her informal support system, rather than intervening in an intrusive way and potentially weakening the client's existing support system.

Approaches need to be client-specific, and may be as varied as the people they serve. Each client's unmet needs are identified through a multidisciplinary assessment process, and the ensuing treatment plan is tailored to that person's individual needs, with consideration given to the capacities and needs of his or her collaterals. An evaluation of the client's informal support system is prerequisite to relying on it as a source of support.

Substance Abuse and Mental Health Services Administration

America's Substance Abuse and Mental Health Services Administration (SAMHSA)[1] supports the British National Health Service's Joint Liaison/Collaborative approach in stating that its report to Congress "is not recommending the creation of a separate system of care for people who have co-occurring substance abuse issues and mental health disorders. Indeed, people with co-occurring disorders must be able to receive their treatment in mainstream systems of care that are well-prepared to support their recovery."

SAMHSA proposes a four-quadrant model of service, referred to as the New York Model,[2] which provides a set of reference points for understanding each person's needs relative to the system's capacity to deliver a full range of services. A graphic depiction of the model follows. The New York Model builds on the fact that people affected by concurrent disorders vary in symptom severity, from less severe mental health and addiction issues to more severe mental health and addiction issues. The model is based on symptom multiplicity and severity rather than on specific diagnoses, it uses language familiar to both mental health and addiction service providers, and it points to windows of opportunity within which providers can act. It identifies levels of service co-ordination, and emphasizes that people are appropriately served through collaborative interventions.

[1] Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders.* Rockville, MD: Author.

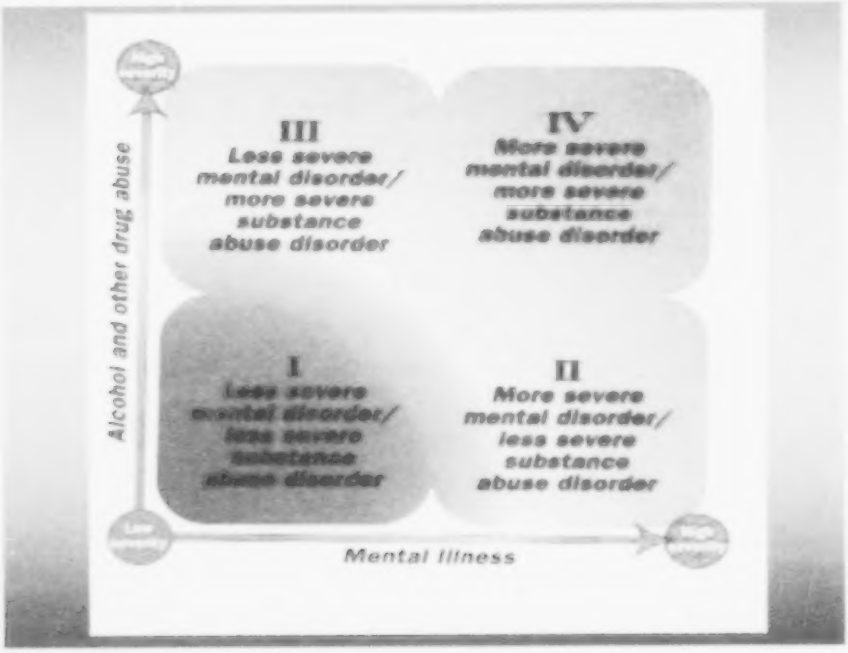
[2] National Association of State Mental Health Program Directors, National Association of State Alcohol and Drug Abuse Directors, & New York State Office of Mental Health. (1998). *National dialogue on co-occurring mental health and substance abuse disorders.* Washington, DC: Authors. Available from New York State Office of Mental Health website, http://www.omh.state.ny.us

Co-occurring Disorders by Severity

III
Less severe mental disorder/ more severe substance abuse disorder
IV
More severe mental disorder/ more severe substance abuse disorder
I
Less severe mental disorder/ less severe substance abuse disorder
II
More severe mental disorder/ less severe substance abuse disorder
Mental Illness

Primary Locus of Care by Severity

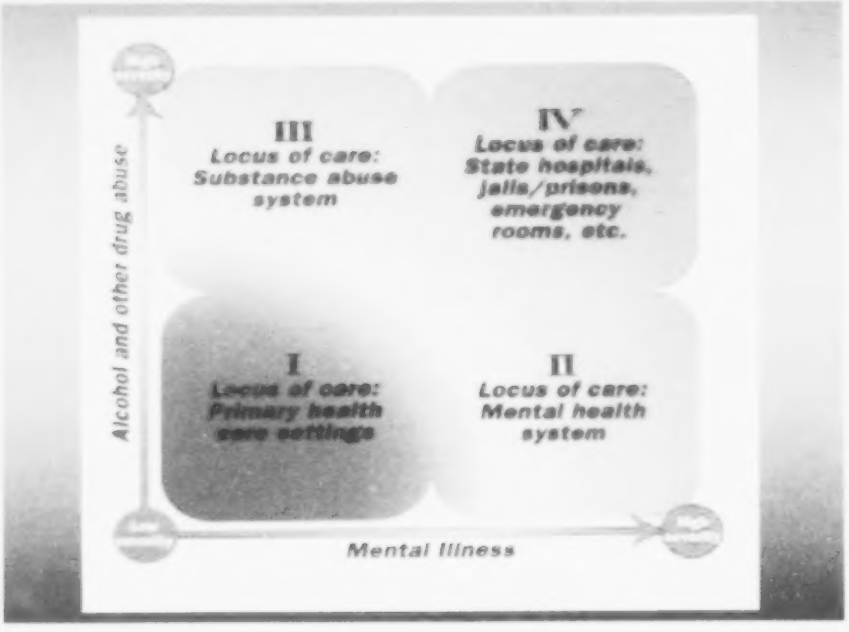
Co-occurring Disorders by Severity


III
Less severe mental disorder/ more severe substance abuse disorder
IV
More severe mental disorder/ more severe substance abuse disorder
I
Less severe mental disorder/ less severe substance abuse disorder
II
More severe mental disorder/ less severe substance abuse disorder
Alcohol and other drug abuse
Mental Illness

– National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders, June 16-17, 1998, Washington, DC

The model's conceptual foundation recognizes that differences in severity should be used to determine the most appropriate service type through which the person receives care. This includes primary health-care services, addictions services and mental health services, as well as the criminal justice system, the child protection system, the homeless service system, and so on. The model's "locus of care" matrix follows.

Primary Locus of Care by Severity



– National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders, June 16-17, 1998, Washington, DC

Implementing this model would require a commitment from health regions, AADAC, physicians and other key partners to flesh out the operational details. For example, the model does not provide the detail required to understand the diagnostic criteria for determining which agency would assume primary responsibility. Although this may seem intuitively obvious, it needs to be spelled out in detail. For the most part, consumers tend to choose their point of access to the health delivery system. Symptoms or health issues of greatest concern, ease of access, and confidence that their needs will be addressed confidentially and respectfully are but a few of the criteria that people use when entering through health service "doors."

Another limitation of a graphic depiction is its potential to suggest that a client's issues are static—contained over time within one quadrant—when in reality, clients can and usually will move between the quadrants as their needs change. For example, a person's health status may improve when his or her prescription medication takes effect, or when he or she completes drug treatment. The criteria used to determine whether it might be appropriate to transfer primary responsibility would need to be clarified and committed to by those involved in service delivery at the local level. Broad system indicators would be developed as a guideline for this community-level decision making.

American Society of Addiction Medicine

The American Society of Addiction Medicine (ASAM)[1] proposes an approach that delineates the following levels of program and staff capacities for serving people with concurrent disorders:

a. Concurrent Disorder Capable Services

ASAM identifies the imperative that all services be "concurrent disorder capable," whether they are primarily focused on addictions or on mental health.

For addictions services, this means that although the service and its staff may have a primary focus on the treatment of addiction-related issues, they are also capable of serving clients who have relatively stable co-occurring mental health problems related to an emotional, behavioural or cognitive disorder. Capability includes screening for the mental health problem, having sufficient knowledge and experience to know when a mental health assessment or intervention is required, and seeking consultation or making an appropriate referral. In the absence of a formal diagnosis, addictions counsellors would take careful note of the client's background, presenting mental health problems or symptoms, age of onset, family history, use of medication, and current or past involvement with mental health services, with a view to adjusting the client's preliminary treatment plan.

[1] American Society of Addiction Medicine. (2001). *ASAM patient placement criteria for the treatment of substance-related disorders* (Rev. 2nd ed.). Chevy Chase, MD: Author.

The addictions counsellor may use a screening tool to help in determining the nature of the client's mental health problems.

Examples of potential referrals to mental health services include a person with a trauma history, experiencing depression and self-medicating by simultaneously using alcohol and other drugs; or a person with a history of depression as a youth who, at the time, was either deliberately or inadvertently non-compliant in taking a prescribed antidepressant and now, as an adult, expresses a long history of alcohol abuse. These needs are consistent with those of people described in Quadrant III of the New York Model. Generally, these people have more severe substance-related problems concurrent with less severe mental health problems. For the most part, these people are able to manage their major life areas.

Addictions counsellors typically address the needs of clients whose psychiatric disorders are stable, and who are capable of independent functioning, so that their mental health disorders do not interfere significantly with their participation in addictions treatment.

Some people may have severe and persistent mental illnesses that are in a relatively stable phase at the time the person is seeking addiction treatment. Others may have difficulties in mood, behaviour or cognition as the result of a psychiatric or substance-induced disorder; or their emotional, behavioural or cognitive symptoms may not rise to the level of a diagnosable mental health disorder.

These people benefit from counselling and co-ordinated mental health interventions, so that the primary therapy can be focused on their substance abuse. Addiction and mental health clinicians would work closely together, co-ordinated by an agreed-upon case manager. This collaboration would include an appreciation for and acceptance of the appropriate use of psychotropic medications that would best serve the client's needs.

While working with the person in recovery, addictions counsellors need to be aware of the person's mental health problem, and alerted if and when his or her mental health status changes. If that should happen, appropriate linkages with mental health services must be in place to help the client optimize his or her health potential.

For mental health services, "concurrent disorder capability" means that although the service and its clinicians may have a primary focus on the treatment of mental health problems, they are also capable of serving clients who have been detoxified and have substance-related problems. The mental health client may need crisis stabilization. Mental health clinicians would have enough knowledge, understanding and experience to screen for the presence of specific addictions, to know when a substance-related assessment or intervention is needed, and to consult with or refer to an addiction service when appropriate.

A mental health clinician would take careful note of the client's overall level of functioning in major life areas, and gather context about the client's history of substance use (including age of onset, family history of substance use, and the impact of that substance use on the family member's major life areas).

Examples of potential referrals to addictions services include a person experiencing depression as he or she progresses through recovery from alcohol abuse; or a youth with conduct disorder who continues to use substances, increases the frequency with which he or she takes them, and is deliberately non-compliant with his or her medication regimen. The mental health therapist may use a screening tool to help in determining the nature of the client's addiction problems.

Mental health services would typically meet the needs of clients whose addiction does not interfere significantly with their participation in their mental health treatment plan. This is consistent with the needs of people described in Quadrant II of the New York Model.

Addiction and mental health services would work together with the client to ensure accurate screening, comprehensive assessment, appropriate referral and a client-centred treatment plan.

b. Concurrent Disorder Enhanced Services

In contrast with a concurrent disorder capable service, a concurrent disorder enhanced service fully integrates services for mental health and substance-related problems in its staffing, services and program content. This is consistent with the needs of people described in Quadrant IV of the New York Model.

Concurrent disorder enhanced programs are appropriate for people who need primary addiction treatment, but who are more symptomatic and/or functionally impaired as a result of their co-existing mental health disorder. These people typically are unstable, or disabled to such a degree that specific psychiatric and mental health intervention, monitoring and stabilization are necessary in order for them to participate in treatment.

All staff are cross-trained to deliver both addictions counselling and mental health therapy. Such programs tend to have relatively high staff-to-client ratios so they are able to closely monitor those who demonstrate psychiatric instability or disability. The primary focus of this service is to stabilize people, with a view to transferring them to a less intrusive service at the earliest opportunity.

An average stabilization period of between one and four weeks may be required. When needed, a concurrent disorder capable program must be immediately available to ensure that there is no interruption in service continuity.

Dr. Ken Minkoff

Dr. Ken Minkoff is recognized as one of America's leading experts on integrated treatment of people with addiction and mental health problems, and on the development of integrated systems of care for these people.

As a starting point for developing a seamless system of shared care, the similarities between mental illness and addictions (adapted from initial work by Dr. Minkoff[5]) are outlined below. Both mental illness and addictions

- have a biological component
- have positive and negative attributes
- have the potential to be chronic and relapsing
- can begin partly as a result of, or be exacerbated by, environmental stressors
- lead to unhealthy behaviour, ineffective coping and social skills, and difficult-to-control emotions
- carry a stigma, resulting in feelings of shame, guilt and failure, all of which affect one's self-concept
- affect other major life areas such as relationships, employment, housing, and leisure
- adversely affect physical, emotional and spiritual health
- affect family members and collaterals

These similarities provide a foundation for blending mental health and addictions treatment strategies for people with concurrent disorders. The major elements of effective strategies for this population include

- engaging clients in services
- retaining clients in active treatment
- providing interventions that facilitate motivation to change
- addressing the relapsing nature of a chronic condition through relapse prevention work[6]
- facilitating re-integration into the community with appropriate support

[5] Minkoff, K. (2000). *Dual diagnosis: An integrated model for the treatment of people with co-occurring psychiatric and substance disorders in managed care system* [Handbook]. Brookline Village, MA: Mental Illness Education Project.

[6] Relapses will inevitably happen. It is useful to expect that clients will return because life difficulties or crises create psychological distress. A measure of success is a readmission before relapse. If and when people choose to reuse services, staff should express gratefulness. Within this framework, the revolving door phenomenon, which has been described as a treatment failure, is in fact a winning strategy because people maintain their ties with the treatment team. It is incumbent upon the case manager to use this readmission to empower the person. Clients often report that trust was the most significant factor in using services when a crisis took place.

Appendix C: The Experts

As part of an evidence-based approach to developing a provincial framework, AADAC sought expert opinions from the following recognized leaders in the fields of addictions and mental health:

Dr. Ken Minkoff is a practicing psychiatrist with a certificate of additional qualifications in addiction psychiatry, and is currently a clinical assistant professor of psychiatry at Harvard Medical School. He is recognized as one of America's leading experts on integrated treatment of people with addiction and mental health problems, and on the development of integrated systems of care for these people. Dr. Minkoff's major professional activity is the provision of training and consultation on clinical services and systems design for people with co-occurring disorders. Dr. Minkoff is a Fellow of the American Psychiatric Association, and a member of the American Academy of Addiction Psychiatrists.

Dr. Jerome Carroll is a consultant with the Alcoholism and Substance Abuse Providers of New York State. He has conducted research, published and lectured extensively on the mental health-substance abuse interface. Dr. Carroll developed the Substance Abuse Problem Checklist and the Mental Health Screening Form-III, instruments designed to help clinicians develop treatment plans and facilitate the counselling process.

Dr. Louise Nadeau is a senior researcher with the RISQ (Recherche et Intervention sur les Substances psychoactives Québec), a team established in partnership with the network of addiction treatment centres in Quebec. Her current research includes a focus on treatment and treatment outcomes for people with addictions and other concurrent disorders. Dr. Nadeau has been chair of the Quebec government's Standing Committee on Addictions (1994-2001); member of the National Forum on Health chaired by the Prime Minister of Canada (1995-1997); member of the Interim Governing Council of the Canadian Institutes of Health Research (1998-1999); and member of the Board of Directors of the Canadian Centre on Substance Abuse (1990-2000). Dr. Nadeau participated as a project team member in developing Health Canada's *Best Practices: Concurrent Mental Health and Substance Use Disorders*.

AADAC

Alberta Alcohol and Drug Abuse Commission
An Agency of the Government of Alberta

For more information, contact your local AADAC office,
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